

## Topic 4: Gender Identity Disorders

### T04-O-01

#### Penoscrotal flap vaginoplasty in Male-to-Female transsexualism

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The transsexual is a person who suffers a profound identity disturbance caused by physical characteristics which do not correspond with mental traits and tendencies.

The persistent sense of contradiction between sexual appearance and inner perception causes a strong need of harmonization. This condition can be reached by undergoing Sex Reassignment Surgery.

Penoscrotal flap vaginoplasty represents the most widely used technique in Male-to-female transsexualism. Other techniques are represented by Simple penile skin inversion and Enterovaginoplasty.

Common surgical steps in performing a penoscrotal flap vaginoplasty are: penile degloving, excision of corpora cavernosa, bilateral orchidectomy, creation of a retroprostatic space where to allocate the neovagina.

Costitution of the neocavity will be made by assembling scrotal and penile flaps by three interrupted sutures at level of cul-de-sac, right and left edges.

Fixation of the neovagina is made by performing a simple, personal technique which expects that prolene stitches are passed through the Denonvillier's fascia and the penoscrotal flap at level of cul-de-sac.

In a 15 years personal experience, we performed 169 SRS operations on M-to-F patients: 103 (61%) were performed as penoscrotal flap vaginoplasty, 57 (34%) as simple penile skin inversion and 9 (5%) as colovaginoplasty.

In our experience, a significant number of patients were satisfied with chosen surgery and felt comfortable with their new post-operative gender. Taking into account all the complications involved none of the patients felt regret and all would recommend the same operation to others.

Overall results of studies carried out on patient satisfaction before and after SRS, show a net post-surgery improvement of patient sexual life.

### T04-O-02

#### Ethical problems of sex reassignment surgery for transgenderism

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**Background:** Few cases of transgenderism were reported in Romania before 1989; these persons were frequently labeled as delinquent and imprisoned for both their sexual orientation and the sexual identity disorder, being in contradiction to the socialist ethical codex. Therefore, they were obliged to hide their need for truth and coming out.

**Objective:** to describe the development of the legislative changes in the field of human rights and their personal consequences.

**Design and methods:** We will describe the case of a young mentally retarded man who asked for sex reassignment surgery and social rehabilitation in spite of poor knowledge about the medical and social consequences. The two steps were fulfilled although at least three major contraindications were ignored.

**Results:** the sex reassignment surgery proved to be unsuccessful, the patient being obliged to endure the status of "no sex". This latter confusion determined the patient to ask a further surgical procedure in order to regain his previous status. Media presented for more than 10 years the case in detail, without any concern of privacy.

**Conclusions:** The application of the current legislation in the field, the fulfillment of the medical, social and vocational conditions along with the real life test and the personal context should be weighted maturely in each case before the surgical reassignment procedures.

### T04-O-03

#### Model of an integrated intervention in a public health service for GID people

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**Objective:** To describe the experience of a specific structure for GID people care.

**Design and method:** CIDIGeM, a Public Health Service (PHS) for GID people, provides a well structured program, according to Italian Standard of Care: eligibility and readiness evaluation, Hormone Therapy under medical and psychological control (Real Life Experience), Sex Reassignment Surgery (SRS) after Court authorisation.

The following features are also provided, in charge of the PHS:

- Hormone therapy;
- Speech therapy and when not enough a surgical intervention;
- Mammoplasty for MtF with breast development of level (BO-1) confirmed through ecography and mammography;
- SRS;
- Medical and psychological follow-up at 6, 12, 24 months after surgery.

**Results:** In 2 years activity:

- 126 GID people applied to the Center, asking for SRS
- 31 of them already authorized for SRS
- 95 of them starting the program
- 75 fulfilled the criteria to enter the program
- 20 underwent SRS (19 MtF, 1 FtM)
- 19 with good outcome or minor negative consequences
- 1 with vagina reconstruction
- 6 had speech therapy
- 5 had breast development examined
- 28 had follow-up

**Conclusion:** Multifactorial aspects of GID request a whole well structured intervention, with the aim of helping every subject to be integrated in the sex they feel to belong to.

## T04-O-04

### Severe osteoporosis with multiple vertebral fractures after gender reassignment therapy - is it male or female osteoporosis?

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**Medical and Family History:** The 47-year old patient E.P. presented with multiple vertebral fractures to our osteologic outpatient clinic. In 1993 our patient had undergone gender reassignment surgery from male to female. Afterwards she had continuously been on hormone replacement therapy. In addition to vertebral fractures, the patient was suffering from a clinically stable colitis which was treated with mesalazine. The patient's mother is suffering from postmenopausal osteoporosis. Osteologic work-up: CTX were elevated (0,68 ng/ml). 25-(OH)-Vitamin D3 indicated a mild deficiency. All other relevant bone parameters were normal. DXA revealed low T-scores at all sites measured: Total hip -4,3/ lumbar spine -3,9. Via bone biopsy osteomalacia and malignant infiltration of the

bone marrow could be excluded. Treatment: Based on the high levels of CTX, an antiresorptive treatment with intravenous ibandronate combined with calcium/vitamin D supplements was initiated. Discussion: In spite of significant endocrine interventions, bone health in transsexual individuals after gender reassignment therapy is rarely considered. The case highlights the need for investigations which closely monitor bone mass before, during and after gender reassignment therapy. In our patient we believe that a vulnerable genetic background (i.e. the positive family history) has been exposed to surgical (male) hypogonadism. Although the patient is receiving hormone replacement, therapy seemed to be insufficient to preserve bone health. In summary, we believe that since she has reached her peak bone mass as a man and therefore displays male bone geometry, female HRT cannot compensate for her skeleton's need for testosterone and estrogens together.

## T04-O-05

### High dose Testosterone (T) treatment has no adverse effects on the endometrium of Female to Male transsexuals (FtM)

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**Objects:** T patches have been approved in Europe for replacement therapy in surgical menopausal women with hypoactive sexual desire. Long-term safety of T administration in women is still unknown. No data exists on the effects of T on the endometrium. The aim of this study is to evaluate the effects of high T doses administered for at least one year on the endometrium.

**Methods:** Endometrial biopsies from 30 FtM treated with T (i.m. injection of 100 mg Testoviron Depot /10 days), 30 postmenopausal women (M) undergoing vaginal hysterectomy and 5 premenopausal women (PrM) undergoing hysteroscopy for infertility problems were collected. Endometrial proliferation was evaluated on the basis of histopathology and expression of the Ki-67. Both M and PrM women had not received hormonal treatment for at least one year.

**Results:** In FtM T and estradiol (E) levels were increased to above normal female levels (T= 4.2+3.4 ng/mL; E=57.5+39.4 pg/mL). At histological analysis, FtM and M had atrophic endometrium and PrM women had proliferative endometrium. The mean Ki-67 expression in the endometrium was similar in FtM and M (1.1+1.1% and 0.6+0.9%) while it was higher in PrM (42.6 + 17.1; vs. FtM and M p= <0.05).

**Conclusions:** Our data suggests that long term, high dose T treatment does not stimulate endometrial proliferation in FtM subjects. Exogenous T administration appears to contrast proliferative effects of estrogens on endometrium.